King County

Employee Benefits Review

October 19, 1999

Garner Consulting

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October 15, 1999

Metropolitan King County Council Members
King County Courthouse
Seattle, WA 98104

Dear Council Members:

On behalf of the Garner Consulting/ARMTech audit team, I am pleased to transmit the Employee Benefits Audit report.

The objectives of the audit were to:

- Review the County's benefit policy;
- Review the adequacy of the County's reserves;
- Review administrative costs;
- Evaluate the County's plan design and plan costs;
- Evaluate the cost of actuarial consulting services; and
- Analyze administrative activities, including legal compliance.

A summary of the audit findings and recommendations follows this letter. Overall, employee benefits are being managed effectively.

Nonetheless, opportunities for improvements exist. Most importantly, the County should adopt a formal benefits philosophy. The County should seriously consider adopting a total compensation orientation.

Our report indicates that, as of the end of June, the incurred-but-not-reported (IBNR) reserve was no longer fully funded. An accounting change made after we submitted our reported restated the balance and the County once again has a fully funded IBNR.

One pending change in State rules may have a major impact on the County. The State of Washington is considering adding a requirement that claim fluctuation reserves be funded. If adopted in its present form, this would be about $6.4 million for the County. If the State adopts this requirement, the County should re-examine whether self-insurance is still advantageous, compared to insuring the benefits.

The Executive's response is appended to our report.

We appreciate this opportunity to have been of service to the County. In closing, we would like to acknowledge the participation of the Oversight Committee. Their diligent review of our works-in-process contributed materially to the relevance of this audit report.

Very truly yours,

John C. Garner, CEBS, CLU, CPCM

JCG:dd

cc: Don Eklund, County Auditor

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EXECUTIVE SUMMARY

This report is a comprehensive review and analysis of the County's self-insured benefit plans. We reviewed:

- Benefit Policy
- Reserves
- Administrative Costs
- Plan Design and Costs
- Actuarial Fees
- Administration.

BENEFIT POLICY

The County should develop a formal benefits philosophy.

We reviewed the County's benefit policy and evaluated alternative labor agreement strategies and found that the County does not have a formal benefit strategy.

The County's approach to benefits has been situational and short term. The County should have a longer-term orientation and a more formal strategy. Having such a strategy would help ensure equity and improve cost stability. For the last negotiations, the County was able to keep benefits and costs almost even with those of the prior three-year period. Because of rising health care costs, it will not be possible to keep level benefits and costs for the next three-year period. The County will need to choose between maintaining benefits and controlling costs.

The County has three alternative approaches:

- Continue to provide above average benefits
- Reduce benefits to the average
- Adopt a total compensation philosophy.

The County should seriously consider adopting a total compensation orientation. Under this approach, benefits are not viewed as separate from compensation. Base salaries, incentive pay and employee benefits are evaluated and negotiated as a single package. A cafeteria plan fits well within a total compensation philosophy. With a typical cafeteria plan, employees receive certain core benefits, plus a number of dollars to spend on other benefits as they see fit.

A cafeteria plan has the following advantages: maximum flexibility for employees to allocate benefit dollars optimally; maximum flexibility for the County to negotiate adjustments to contributions for benefits; ease of conducting cost-based total compensation surveys.

If the County adopts a total compensation philosophy, a major change in negotiating strategy with the unions will be required. In the past, the County and the unions have negotiated benefits. Under a total compensation approach, the County would negotiate a certain floor level of benefits, with a dollar amount negotiated in addition to the core benefits. The County could then offer an even wider array of benefit choices, including cash.

The biggest disadvantage to the total compensation philosophy is the period of transition. During the transition costs will increase initially. But that amount can be locked in for three years. The initial increase in costs is exchanged for lower rates of increase in the future. All parties could win: the unions would have an initial increase in benefit dollars, employees would have more choices and the County would have more stable future costs.

Appendix I details the specific differences in plan design that make the County benefits above the average.

RESERVES

In this portion of the analysis, we

- Reviewed the adequacy of the County's reserves
- Determined whether the reserves were adequately funded.

There are two types of reserves:

- An incurred-but-not-reported reserve (IBNR) is the amount required to pay claims incurred on or before a certain date, but paid after that date.
- A claim fluctuation reserve (CFR) is a contingency reserve in case claims are more than expected.

Incurred-But-Not-Reported Reserve

The amount of the County's incurred-but-not-reported reserve (IBNR) calculated by the actuary is adequate without being excessive.

Our actuary's analysis of the last two annual actuarial reports prepared by William M. Mercer, Inc. showed that the reports contained no deficiencies. The calculations of IBNR were made using standard actuarial methodology. The IBNRs calculated for December 31, 1996 and December 31, 1997 were within 2% of the actual amount required. This means that the IBNR has not been exceeded. Neither has it been excessive. The amount calculated by the actuary is a liability of the plan. The state requires this amount to be funded.

As of the end of June 1999, the IBNR is no longer fully funded, as required by the State.

Claim Fluctuation Reserve

The County has other assets that could be used in an emergency, but the reserves are primary designated for other purposes and would have to be repaid to whatever fund they were borrowed from.

In the absence of legal requirements, it would be appropriate to maintain a CFR of 5% of annual claims.

The standard actuarial practice is to establish a claim fluctuation reserve (CFR) anywhere from 0% to 10% of annual claims. Without considering the State's legal requirements, a CFR of 5% would be sufficient.

The median CFR in our survey was 17.4% of paid claims, compared to 2.8% for the County. Only one agency with a CFR had a lower percentage. This means that, compared to other self-insured governmental entities in Washington, the County had less of a CFR to draw upon if claims were higher than expected. As of the end of June 1999, the County's CFR had been used to pay claims that were higher than expected.

Currently, pending State requirements call for a CFR dedicated exclusively to benefits.

ADMINISTRATIVE COSTS

The County's administrative costs are reasonable.

We reviewed the reasonableness of third party administrative costs. Survey results revealed that the County's fees are at or below the average.

PLAN DESIGN AND COSTS

The County has a generous health benefit program compared to other governmental agencies in Washington.

We evaluated the County's plan design and plan costs. Our analysis shows that the employer-provided value of the County's health benefits for most employees is 12.2% higher than the average of other surveyed agencies. We do not have enough data on the part-time transit workers or deputy sheriffs to draw meaningful conclusions as to how their benefits compare to the other agencies.

The County's costs for its freedom-of-choice medical plans (the PPOs and point-of-service plans) are reasonable, given their value.

After adjusting for the value of benefits, the County pays 1.8% more than the average. If we look only at cost, without regard to value, KingCare Preferred is the most expensive freedom-of-choice medical plan in our survey at 30.0% above average.

The County is doing a better than average job negotiating with its HMOs.

The County's cost for its HMOs is 15.8% less than for other surveyed agencies' HMOs, when taking the value of the plans into consideration.

ACTUARIAL FEES

The County's actuarial fees are reasonable.

We evaluated the cost of actuarial consulting service to the County's self-insured benefit plans. Based on the survey results and our experience, the County's actuarial fees are reasonable.

ADMINISTRATION

The Benefits and Well-Being Section of the Office of Human Resources Management (Benefits Office) has a knowledgeable and talented leadership team, which has already recognized a number of opportunities for improvement, such as training staff and documenting procedures and is also doing an excellent job in communication with employees.

We reviewed the efficiency, effectiveness and reasonableness of the organization, rules and administrative activities of the self-insured employee benefits program and assessed the adequacy of compliance to legal/administrative requirements. We also evaluated whether the County is filing accurate and timely information with the State of Washington as required by law for the self-insured program.

The County should formalize its appeal procedure in writing.

The County relies on the individual carriers and administrators to handle the initial levels of appeals. Due to the fact that the County handles appeals concerning eligibility and appeals that have been referred by the administrators, a written appeal procedure should be implemented describing the process.

The County should conduct regular audits of its administrators.

It has been two years since the County has audited any of its third party administrators. Given the large dollar volume the medical plan administrator is processing for the County, the County should conduct annual audits. The County should conduct audits of the dental plan administrator at least every two years and audits of the prescription drug, vision and COBRA administrators at least every three years.

The County is meeting all applicable Federal legal requirements regarding plan design and most federal notice and administrative requirements.

The County needs to make the following changes to meet notice and administrative requirements:

– The County needs to modify its booklets to include recent changes in the law regarding notice requirements.

– The Omnibus Budget Reconciliation Act of 1993 requires employers to have written procedures for handling Qualified Medical Child Support Orders. The Benefits Office is beginning to document its procedures; this procedure should be given higher priority because it is legally required.

– The County should either create a single plan document governing all three self-insured plans or offer separate COBRA elections for each plan.

At this time, the County does not have a fully funded IBNR; otherwise the County is in compliance with all applicable State laws.

However, the State's Health and Welfare Advisory Board is considering adding a requirement that claim fluctuation reserves be funded, which may require the County to fund a claim fluctuation reserve of about $6.4 million.

The County's insurance carriers and HMOs refuse to comply with the terms of a County ordinance related to benefits for employees (and their dependents) who are on military leave.

The federal Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), requires health plan continuation for 18 months. Prior to the enactment of USERRA the County enacted an ordinance continuing all employee benefits for employees on a military duty leave without a time limit. The County's HMOs and life and disability insurers refuse to assume any more risk than required by USERRA.

The County has two options: self-insure the benefits, which could be expensive, or the Council could repeal the ordinance.

SURVEY METHODOLOGY

The County has traditionally compared its employee benefits with those of ten other large governmental employers in Washington. All ten initially agreed to participate in the survey we conducted as part of this project. The following employers actually participated:

City of Bellevue

City of Seattle

City of Tacoma

Pierce County

Port of Seattle

Snohomish County

State of Washington

University of Washington.

We used information from these employers to compare plan designs and costs.

Some of the subjects we studied apply only to self-insured medical, dental and vision plans. Only five of the ten employers to which the County compares itself are self-insured. To supplement the five initial participants, we asked three other self-insured governmental employers in Washington to participate. All agreed, but only the following employers actually participated in the self-insurance portion of the survey:

City of Bellevue

City of Spokane

City of Tacoma

Spokane County

State of Washington

Tacoma School District.

For both parts of the survey (plan design/cost and self-insurance), some employers did not answer all the questions.

In summary, out of 13 governmental agencies who agreed to participate in one or both parts of the survey, 11 participated. Eight employers provided plan design information. Six responded to questions related to self-insured plans. Three participated in both parts.

Because of the low response rate on self-insured plans, we obtained supplemental information from the State about reserves.

BACKGROUND

Prior to January 1, 1996, the County and Metro had separate employee benefits programs, each operating under different assumptions and procedures.

The County used a coalition approach, similar to what is now used with the Joint Labor Management Insurance Committee, to bargaining benefits for most unions. The County paid the premiums in full for both the employees and their dependents.

Metro negotiated benefits packages separately with each of its five bargaining units and had a sixth plan for non-represented employees. All plans were fully insured and each group had four or five plans from which to choose. Metro contributed an amount equal to the lowest cost plan. Employees who wanted better benefits paid the difference.

The 1995 per employee contributions by the County and Metro to health benefits were almost identical.

The Council and the Executive directed the Benefits and Well-Being Section of the Office of Human Resources Management (Benefits Office) to negotiate with the Joint Labor Management Insurance Committee and seek benefits for County and Metro employees that would cost no more than 1995's and not require employee contribution.

The resulting package included:

- A choice of five medical plan options composed of slightly lower benefit levels than Metro employees had had, but slightly better than the County employees had enjoyed
- A self-insured dental plan, with enhanced benefits for Metro and County employees
- A self-insured vision plan with enhanced benefits for County employees
- A group term life with accident and dismemberment with enhanced benefits for County employees
- A long term disability (LTD) plan with enhanced benefits for County employees.

The plans went out to bid in the fall of 1995 and contracts were signed for 1996 through 1998.

During 1998 the Benefits Office sought guidance from the Council for negotiating the benefits package for 1999 through 2001. Council directed the Benefits Office to maintain present costs but not to sacrifice any benefits. Minor reductions in benefits were negotiated keeping the total cost to the County the same as it would have been if no changes were made.

The County has asked us to focus our analysis on the following self-insured programs:

Plan	Employee	Administrator
Medical -- Preferred Provider Organization (PPO) plans, known as KingCare Preferred and KingCare Basic	Available to all employees, except deputy sheriffs	Aetna US Healthcare (formerly Ethix) Subcontracts to Express Scripts for prescription drug administration
Dental	Provided to all employees	Washington Dental Service
Vision	Provided to all employees, except deputy sheriffs	Vision Service Plan

ProBusiness Administrative Services (formerly Benesphere) administers the group health plan continuation requirements for the County for both insured and self-insured plans, as required under the federal law known as COBRA.

To analyze the design and cost of the County's benefit plans, we also reviewed the following insured medical plans:

Type of Plan	Insurer/HMO	Employees
Point-of-Service (POS) plan known as PacifiCare Choice	PacifiCare	Available to all employees, except deputy sheriffs
Health Maintenance Organization (HMO) known as Alliant	Group Health/Virginia Mason	Available to all employees, except deputy sheriffs
HMO	PacifiCare	Different plan designs are available to deputy sheriffs and all other employees
PPO	Regence	Deputy sheriffs
HMO	Group Health Cooperative	Deputy sheriffs

Collectively, the PPO and POS plans are referred to as freedom-of-choice medical plans, because they provide some level of benefits regardless of the provider the patient uses. Similarly, the dental plan is a freedom-of-choice plan.

The enrollments in the plans as of May, 1999 were as follows:

Plan	Enrollment
Washington Dental Service	13,002
Vision Service Plan	12,483
KingCare Preferred	6,647

Plan	Enrollment
Alliant	2,664
PacifiCare HMO	1,616
PacifiCare POS	1,267
Regence	326
PacifiCare Deputy Sheriffs	212
KingCare Basic	210
Group Health Cooperative	69

The 1998 and 1999 budgets for the self-insured plans are:

Plan	1998 Budget	1999 Budget
Medical	$22,110,129	$30,613,660
Dental	11,740,251	13,882,068
Vision	1,290,879	1,699,484

BENEFIT POLICY

The County should develop a formal benefits philosophy.

We reviewed the County's benefit policy and evaluated alternative labor agreement strategies. To address these concerns, we interviewed some of the County's senior executives (identified in Appendix II). We also reviewed the strategy statement for the Office of Human Resources Management (OHRM), whose mission is "Leadership in achieving and supporting an excellent work force."

The manager of the Benefits Office interacts with the Labor Relations Manager and the Director of Human Resources to accomplish strategic planning. Managers reporting to the Director of Human Resources are building a strategic planning group. An implementation committee of five managers has met and made proposals for a business plan for the Office of Human Resources Management.

One of the objectives of the Office of Human Resources Management is stated as follows:

> Develop consensus within and between the Executive and Council on the philosophical framework for employee benefits and related work-life programs; develop and implement programs within that framework.

At this time, the County has no articulated benefits strategy or comprehensive labor policy with regard to benefits.

The County's approach to benefits has been situational and short term. The County should have a longer-term orientation and a more formal strategy. Having such a strategy would help ensure equity and improve cost stability. For the last negotiations, the County was able to keep benefits and costs almost even with those of the prior three-year period. Because of rising health care costs, it will not be possible to keep level benefits and costs for the next three-year period. The County will need to choose between maintaining benefits and controlling costs.

The County has three alternative approaches:

- Continue to provide above average benefits
- Reduce benefits to the average
- Adopt a total compensation philosophy.

The County should seriously consider adopting a total compensation orientation. Under this approach, benefits are not viewed as separate from compensation. Base salaries, incentive pay and employee benefits are evaluated and negotiated as a single package. A cafeteria plan fits well within a total compensation philosophy. With a typical cafeteria plan, employees receive certain core benefits, plus a number of dollars to spend on other benefits as they see fit. Since the County does not have the resources to provide every employee with the benefits that employee needs or wants, a cafeteria plan approach allows employees to decide which benefits are most important. For example, a two-income family now receives free dental and vision care. That family may need child care more than dental or vision coverage. If the County had a cafeteria

plan, the County employee could opt out of the dental and vision plans and redirect the County's dollars into a more meaningful benefit - child care in this example.

A cafeteria plan has the following advantages: maximum flexibility for employees to allocate benefit dollars optimally; maximum flexibility for the County to negotiate adjustments to contributions for benefits; ease of conducting cost-based total compensation surveys.

Many governments make a trade-off between base salaries and benefits by offering a competitive total compensation package with generous benefits and base salaries slightly below the market averages. Such compensation packages, coupled with job security, make government careers attractive to many. It appears that the County has, consciously or unconsciously, adopted this approach in the past. While this approach may have worked in the past, it is unlikely to work well in the future because of anticipated increases in health care costs and a lack of flexibility for employees.

If the County adopts a total compensation philosophy, a major change in negotiating strategy with the unions will be required. In the past, the County and the unions have negotiated benefits. Under a total compensation approach, the County would negotiate a certain floor level of benefits, with a dollar amount negotiated in addition to the core benefits. (This would be very similar to the approach taken with the part-time transit workers.) The County could then offer an even wider array of benefit choices and employees could each choose how to spend their benefit dollars. Cash could also be an option.

A change to a total compensation philosophy has advantages, but the biggest disadvantage is the period of transition. In making such a change, it is impossible to keep total costs the same, provide the same level of benefits and provide equal pay for equal work. During the transition costs will increase initially. If the negotiators recognize that the initial increase in costs is in exchange for lower rates of increase in the future, all parties could win: the unions would have an initial increase in benefit dollars (although not necessarily for all members), employees would have more choices and the County would have more stable costs in the future.

If the County does not wish to pursue a total compensation philosophy, another approach would be to embrace the County's generous benefits and use them as a selling point to recruit and retain employees (retention has been a problem).

If the County wanted to maintain an overall compensation package that is competitive, but not above average, it would mean holding the line on cash compensation until the overall package came into balance. Alternatively, the County could decide to maintain competitive cash compensation and offer an above average benefit program. Doing so would put the County in a more competitive position with regard to the private sector.

We were repeatedly told of employees the County has lost to private sector employers offering substantially higher base pay. As part of the benefits philosophy, the Council should clearly define whether it will compare itself to the private sector when evaluating compensation and benefits.

Another alternative is to state that the County's philosophy is to maintain competitive benefits, meaning benefits within 10% of the average for the comparison group.

The County could then negotiate reduced benefits so that the County's benefit package is average for the comparison group.

Appendix I details the specific differences in plan design that make the County benefits better than average.

As part of having an overall strategic plan for benefits, the Council needs to decide on an approach to funding the self-insured programs.

If the State does not require a claim fluctuation reserve (CFR), then the County will have the option of doing without one. If the County decides not to have a CFR, it will need to identify an alternative source to fund claims and other expenses that exceed expectations.

RESERVES

In this portion of the analysis, we

- Reviewed the adequacy of the County's reserves
- Determined whether the reserves were adequately funded.

To address these concerns we analyzed the actuarial reports prepared by the County's consulting actuary and the studies produced by the administrators showing the lag between the time claims were incurred and the time they were paid. We also surveyed other large governmental self-insured programs in Washington and obtained public information from the Office of Risk Management of the State of Washington.

There are two types of reserves:

- An incurred-but-not-reported reserve (IBNR) is the amount required to pay claims incurred on or before a certain date, but paid after that date.
- A claim fluctuation reserve (CFR) is a contingency reserve in case claims are more than expected.

INCURRED-BUT-NOT-REPORTED RESERVE

The amount of the incurred-but-not-reported reserve (IBNR) calculated by the actuary is adequate without being excessive.

Our actuary's analysis of the last two annual actuarial reports prepared by William M. Mercer, Inc. concludes that the reports contained no deficiencies. The calculations of IBNR were made using standard actuarial methodology. The IBNRs calculated for December 31, 1996 and December 31, 1997 were within 2% of the actual amount required. This means that the IBNR has not been exceeded. Neither has it been excessive. The actuary updates the IBNR calculation twice a year; the most recent update was in April of 1999. Two analyses per year is reasonable. The actuary is an independent contractor working through the County's consultant. As of the end of June 1999, the IBNR is no longer fully funded, as required by the State. The State does not mandate a specific amount of IBNR, but does require that the amount determined by the actuary be fully funded.

We obtained the following data from the State Office of Risk Management. (We also added data from one survey respondent not reported to us by the Office of Risk Management.) The IBNRs as a percentage of paid claims as of the end of the last plan year reported for self-insured governmental programs were:

	Coverage				
Employer	**Medical**	**Drugs**	**Dental**	**Vision**	**%**
19	X				40.4%
35	X	X		X	32.7%

	Coverage				
Employer	**Medical**	**Drugs**	**Dental**	**Vision**	**%**
36	X	X	X	X	21.9%
17	X	X	X	X	21.0%
11			X		20.6%
22	X	X	X		19.4%
7	X	X		X	18.6%
14	X	X	X	X	18.2%
21	X	X	X	X	18.0%
King County	X	X	X	X	17.4%
25	X	X		X	17.4%
34	X	X	X	X	17.4%
33	X	X		X	16.7%
24			X		16.5%
5	X	X	X	X	16.2%
15	X	X	X	X	15.8%
13	X	X	X	X	15.4%
8	X	X		X	15.3%
29	X	X	X	X	15.3%
20	X	X	X	X	15.0%
10	X	X	X	X	14.2%
32	X	X	X	X	14.0%
27	X	X	X	X	13.5%
6	X	X		X	13.1%
4				X	13.0%
3	X	X		X	12.9%
37	X	X	X		12.8%
23				X	12.6%
31	X	X	X	X	12.4%
26			X	X	12.0%
2	X	X			12.0%
28	X	X	X	X	11.9%
30			X	X	10.0%
9			X		9.0%
18	X	X	X	X	2.7%
1			X	X	2.6%
16	X	X	X	X	0.0%

This shows that the County's IBNR, as a percentage of paid claims, is above average, but not in the highest 25%. (Some surveyors consider results not in the highest or lowest 25% to be "normal".) This reinforces our finding that the Mercer actuarial calculation is reasonable.

CLAIM FLUCTUATION RESERVE

The County has other assets that could be used in an emergency, but the reserves are primarily designated for other purposes and would have to be repaid to whatever fund they were borrowed from.

In the absence of legal requirements, it would be appropriate to maintain a CFR of 5% of annual claims.

At the present time, a claim fluctuation reserve (CFR) is not required by the State. The CFRs as a percentage of paid claims were:

	Coverage				
Employer	**Medical**	**Drugs**	**Dental**	**Vision**	**%**
9			X		491.4%
2	X	X			131.1%
11			X		100.8%
25	X	X		X	100.4%
30			X	X	95.1%
28	X	X	X	X	90.0%
10	X	X	X	X	79.2%
15	X	X	X	X	65.3%
4				X	61.1%
27	X	X	X	X	57.5%
34	X	X	X	X	51.3%
7	X	X		X	49.9%
3	X	X		X	44.3%
20	X	X	X	X	35.7%
31	X	X	X	X	29.6%
22	X	X	X		25.9%
26			X	X	25.2%
23				X	17.4%
36	X	X	X	X	17.4%
32	X	X	X	X	17.4%
29	X	X	X	X	15.8%
14	X	X	X	X	15.0%
6	X	X		X	11.3%
24			X		9.4%
17	X	X	X	X	8.4%
18	X	X	X	X	8.3%
37	X	X	X		7.8%
1			X	X	5.0%
King County	X	X	X	X	2.8%

	Coverage				
Employer	**Medical**	**Drugs**	**Dental**	**Vision**	**%**
21	X	X	X	X	2.6%
5	X	X	X	X	0.0%
8	X	X		X	0.0%
13	X	X	X	X	0.0%
16	X	X	X	X	0.0%
19	X				0.0%
33	X	X		X	0.0%
35	X	X		X	0.0%

Our study of other governmental self-insured programs in Washington found that over 80% have a CFR. The median CFR in our survey was 17.4% of paid claims. Of those agencies with a CFR, only one has a smaller CFR than the County. This means that, compared to other self-insured governmental entities in Washington, the County had less of a CFR to draw upon if claims were higher than expected. Since larger plans have less fluctuation, the County has less need for a CFR than any other agency monitored by the State. As of the end of June 1999, the County's CFR had been used to pay claims that were higher than expected.

Many private sector employers do not maintain claim fluctuation reserves. If claims prove to be more than expected, they shift other assets to cover the fluctuation. The County does not have a pool of other assets that it can readily access. All County reserves are primarily designated for some other purpose. Therefore, it would be advantageous to have a claim fluctuation reserve.

The standard actuarial practice is to establish a CFR anywhere from 0% to 10% of annual claims. The actual level established for contingency reserves will depend on such things as the type of benefits provided, the size of the group, the availability of other financial resources and any applicable laws. Without considering the State's legal requirements, a CFR of 5% would usually be sufficient for the County to cover actual claims. Currently pending State requirements call for a CFR dedicated exclusively to benefits.

ADMINISTRATIVE COSTS

The County's administrative costs are reasonable.

We reviewed the reasonableness of third party administrative costs, including benchmarks for other governmental self-insured programs. To address these concerns we surveyed other large governmental self-insured programs in Washington.

The basis of calculating third party administrator (TPA) fees varies by employer and by plan; some TPAs charge per employee, others per claim, etc. We calculated average monthly fees per employee by dividing total annual fees by the number of employees, then dividing by 12, giving the following results for medical plan administration:

Employer	Fees Per Employee Per Month
1	$26.92
6	21.70
2	20.72
4	17.79
King County	16.86
3	14.97
5	14.37

Note: The employer numbers in this section are not the same as in the prior section.

The dental fees are:

Employer	Fees Per Employee Per Month
2	$6.19
6	5.62
King County	5.18
4	5.14
3	5.09
5	3.07

The vision fees are:

Employer	Fees Per Employee Per Month
King County	$1.20
3	0.45

As a percentage of paid claims, medical administration fees were:

Employer	Fees as a % of Paid Claims
6	9.05%
2	8.83
5	5.91
King County	4.83
4	4.55

Dental administration fees were:

Employer	Fees as a % of Paid Claims
2	9.05%
6	8.50
5	7.53
4	7.12
King County	6.61

Total claim administration fees for all medical, dental and vision plans combined, as a percentage of total paid claims were:

Employer	Fees as a % of Paid Claims
1	11.22%
2	8.90
6	8.85
3	7.14
5	6.48
King County	5.63
4	4.91

Only two respondents answered our questions regarding COBRA fees (the others may administer COBRA internally and not pay a fee.)

As a percentage of paid claims, the COBRA fees were:

Employer	COBRA Fees as a % of Paid Claims
1	0.21%
King County	0.09
2	0.02

COBRA fees are influenced more by the turnover in a population than the fee level. Based on our experience, the COBRA administration fee structure is higher than average. We compared the ProBusiness fees to COBRA administration fee proposals we have received recently for three other clients (two smaller, one larger). For each client, we received six to eight proposals. The ProBusiness fees would have been the highest or second highest for each of these clients. The COBRA administration fees are higher than we are used to seeing.

As the above information demonstrates, the County's fees are consistently average or lower than average. The only exception is the administrative fee for the vision plan, where we only had information from one other employer. That employer does not use VSP. The County's fees are less than the VSP fees for three non-governmental employers whose information we have in our files.

Survey results revealed that the County's fees are at or below the average.

PLAN DESIGN AND COSTS

The County has a generous health benefit program compared to other governmental agencies in Washington. We do not have enough data on the part-time transit workers or deputy sheriffs to draw meaningful conclusions as to how their benefits compare to other agencies.

We evaluated the County's plan design and plan costs.

To address these concerns we surveyed other large governmental self-insured programs in Washington. We conducted an actuarial analysis of the total value and the employer-provided value of the plans offered by the responding governmental employers.

For comparison to other survey participants, we calculated a point value for each employer's plans, based on the health plan valuation methodology proposed by the American Academy of Actuaries for use with Internal Revenue Code Section 89. For employers that base contributions on a dollar amount that varies with family size, we used an average contribution per employee.

We compared the benefits offered under the County's PPO plans to freedom-of-choice plans offered by the other employers and then compared the benefits offered under the County's HMO plans to those offered by the other employers. In comparing benefits we compared deductibles, out-of-pocket limits, coinsurance amounts, hospital benefits, benefits for professional services, prescription drugs, mental health benefits and other items, such as ambulance and physical therapy benefits.

The total plan values for the freedom-of-choice plans are as follows:

Employer	Type of Plan	Total Point Value
6	POS	1,276
1	PPO (Public Safety)	1,256
King County	POS	1,199
6	PPO	1,195
3	PPO (Public Safety)	1,191
King County	PPO (KingCare Preferred)	1,190
2	POS	1,175
4	POS	1,165
5	POS	1,155
1	PPO	1,154
3	PPO	1,107
4	PPO	1,095
King County	PPO (KingCare Basic)	1,063
King County	PPO (Deputy Sheriffs)	1,057
5	PPO	982
7	PPO	979

Employer	Type of Plan	Total Point Value
8	PPO	979
2	PPO	925
1	High Deductible	796

Note: Employer numbers in this section are not the same as in other sections.

Note: We have not repeated lines, even if more than one would be appropriate. For example, some employers offer multiple HMOs with the same plan design. The benefit is listed only once above, but may be listed more than once in later sections because the premiums and employer contributions differ.

The average point value of the County plans is 1,128 (giving all plans equal weight), compared to 1,095 for all the other plans. However, if we exclude the deputy sheriffs and the Basic plan, the average point value for the County is 1,195. If we exclude the public safety plans and the high deductible plan, the average point value for other plans is 1,099. This means that for most County employees, the freedom-of-choice plans available are 8.7% above the average, if we give all plans equal weight. If we give equal weight to each employer (with each plan given equal weight in calculating each employer's value), the County's freedom-of-choice plans are 12.1% above the average of the other employers, which is 1,066. This approach, of weighting employers equally, rather than plans, is the approach used for the other comparisons in this section.

The average of the other point-of-service (POS) plans is 1,193, compared to 1,199 for the County, a negligible difference.

The County's average preferred provider organization (PPO) plan is 1,103 points, compared to 1,086 for all other PPOs. However, KingCare Preferred is worth 1,190 points, versus an average of only 1,052 for other PPOs, excluding public safety plans, a difference of 13.1%.

When we take out the value of employee contributions, we find the following employer-provided values for freedom-of-choice plans:

Employer	Type of Plan	Employer-Provided Value
6	POS	1,276
King County	POS	1,199
6	PPO	1,195
3	PPO (Public Safety)	1,191
King County	PPO (KingCare Preferred)	1,190
2	POS	1,175
5	POS	1,155
1	PPO	1,154
3	PPO	1,107
4	PPO	1,095
1	PPO (Public Safety)	1,093

Employer	Type of Plan	Employer-Provided Value
4	POS	1,072
King County	PPO (KingCare Basic)	1,063
King County	PPO (Deputy Sheriffs)	1,057
5	PPO	982
1	PPO	969
7	PPO	969
8	PPO	969
1	High Deductible + Cash Back	955
2	PPO	925
2	PPO (Public Safety)	740

Note: We have excluded part-time transit employees from this analysis because most of the other agencies surveyed do not have comparable employees. We have included information on the deputy sheriffs and public safety employees for other agencies, but this is for information only. A number of the other agencies are not comparable.

The average employer-provided point value of the County plans is 1,127, compared to an average of 1,058 for the other employers. If we exclude the deputy sheriffs and the Basic plan, the average for the County is 1,195, compared to an average for other employers, excluding public safety and the high deductible plan, of 1,068. This means that for most County employees, the employer-provided value of the freedom-of-choice plans is 11.9% more than for other employers. The average employer-provided value of the other POS plans is 1,170, compared to 1,199 for the County.

The employer-provided value of the County's POS plan is 2.5% more than the average of the other POS plans.

The average employer-provided value of the other PPO plans (excluding public safety) is 1,041, compared to 1,190 for KingCare Preferred.

The employer-provided value of KingCare Preferred for most employees is 14.3% more than the average of the other PPOs.

The total plan values for the health maintenance organizations (HMOs) are:

Employer		Total Point Value
King County	(PacifiCare – Deputy Sheriffs)	1,286
King County	(PacifiCare)	1,214
1	(Public Safety)	1,192
King County	(Group Health Cooperative - Deputy Sheriffs)	1,189
6		1,167
1		1,166
3		1,165

Employer		Total Point Value
King County	(Alliant)	1,164
5		1,158
2		1,139
7		1,086
8		1,086
7		1,085
8		1,085

The average point value of the County HMOs is 1,213, compared to an average for other employers of 1,140, a difference of 6.4%.

When we take out the value of employee contributions, we find the following employer-provided values for HMOs:

Employer		Employer-Provided Value
King County	(PacifiCare – Deputy Sheriffs)	1,286
King County	(PacifiCare)	1,214
King County	(Group Health Cooperative - Deputy Sheriffs)	1,189
6		1,167
3		1,165
King County	(Alliant)	1,164
5		1,158
2		1,139
7		1,074
8		1,074
7		1,063
8		1,063
7		1,043
8		1,043
7		1,042
8		1,042
1	(Public Safety)	1,037
1		1,014
7		998
8		998
2	(Public Safety)	934

The average employer-provided point value of the County HMOs is 1,213, compared to an average for other employers of 1,092. If we exclude deputy sheriffs, the average for the County is 1,189, compared to an average for other employers, excluding public safety, of 1,104.

For most County employees, the employer-provided value of the HMOs is 7.7% more than for other employers.

We understand that when the KingCare Basic and KingCare Preferred plans were created, employees had a financial incentive to choose the Basic plan. Part-time transit workers still have such an incentive, since they pay a percentage of the projected cost. Other employees do not pay for coverage and there is no longer a financial incentive to choose the Basic plan. Therefore, there is no rationale for choosing the Basic plan, although over 1% of the employees (not counting part-time transit workers) are in the plan. We assume these employees chose it when there was a reason to do so and they simply failed to read the open enrollment materials. We understand that the County and the unions agreed to leave the Basic plan in place, but we question the logic of doing so. We also understand that the County cannot unilaterally improve benefits for bargained employees.

The Basic plan should be eliminated if there is no reason for an employee to choose it.

If the County adopts a total compensation philosophy, the rationale for retaining the plan would return by proving a financial incentive to choose the Basic plan.

We valued the dental and vision plans using the same methodology as for the medical plan.

All County employees are in the same dental plan, which allows them the freedom to choose any provider, although benefits are better if a Washington Dental Service provider is used (most dentists do belong to WDS). Some of the other agencies we surveyed also offer prepaid dental plans. Employee out-of-pocket amounts are typically less for prepaid plans, but employees can only receive benefits from a limited number of dentists. We did not value the prepaid plans. The total values for the freedom-of-choice dental plans are as follows:

Employer	Total Point Value
4	227
King County	207
1	183
2	181
6	181
1	167
1	163
7	160
8	160
3	147
5	140

The average value of the other dental plans is 171 points, which means the County plan is 21.1% better than the average.

The employer-provided values for the dental plans are as follows:

Employer		Employer-Provided Value
4		227
King County		207
2		181
6		181
1	(Public Safety)	160
7		160
8		160
1		150
1	(Public Safety)	150
3		147
2	(Public Safety)	145
1		141
1		140
5		140

The average employer-provided value of the other dental plans is 166 points, which is well below the County. Excluding public safety, the average of the other employers is 168 points.

The employer-provided value of the County dental plan is 23.2% above average.

The total values for the vision plans are as follows:

Employer	Total Point Value
6	45
King County	43
2	37
4	36
6	36
5	35
7	31
8	31
1	30
4	28
3	25
1	5

The average value of the other vision plans is 31 points, which means the County's plan is worth 38.7% more than the average.

The employer-provided values for the vision plans are as follows:

Employer	Employer-Provided Value
6	45
King County	43
2	37
4	36
6	36
5	35
7	30
8	30
7	29
8	29
4	28
7	28
8	28
3	25
1	5

The average employer-provided value of the other vision plans is 30 points, which is below the County.

The employer-provided value of the County vision plan is 43.3% above average.

The vision plan contains two unusual features:

1. Most vision plans only apply co-payments to eye examinations. The County's co-payments apply to any service.

2. Most scheduled vision plans, such as the non-VSP benefits, do not have co-payments. The County applies a co-payment, effectively reducing the scheduled benefit.

- The co-payments should apply only to eye examinations. In addition to being standard practice, it would make claim administration easier.

- The co-payment for non-VSP providers should be eliminated. In addition to being less confusing and standard practice, it would make claim administration easier.

Many combinations of medical, dental and vision plans are available. In an attempt to compare overall values, we added together the employer-provided values for the most valuable PPO, the most valuable freedom-of-choice dental plan and the most valuable vision plan available for each non-public safety employee, with the following results:

Employer	Employer-Provided Point Value
King County	1,440
6	1,421
4	1,358
1	1,309
3	1,279
7	1,159
8	1,159
5	1,157
2	1,143

As shown, the County has the most generous overall package of benefits for KingCare Preferred participants, compared to PPO plan participants at the other governmental agencies surveyed. The average for the other employers is 1,248 points.

The County is 15.4% above the average for medical, dental and vision benefits for KingCare Preferred participants.

We made a similar calculation for POS plan participants, with the following results:

Employer	Employer-Provided Point Value
6	1,502
King County	1,449
2	1,393
4	1,335
5	1,330

As shown, the County does not have the most generous overall package of benefits for POS participants, compared to POS plan participants at the other governmental agencies surveyed, but is above the median. The average for the other employers is 1,390 points.

The County is 4.2% above the average for medical, dental and vision benefits for POS plan participants.

We made a similar calculation for HMO plan participants, with the following results:

Employer		Employer-Provided Value
King County	(PacifiCare)	1,464
King County	(Alliant)	1,414
6		1,393

Employer	Employer-Provided Value
2	1,357
5	1,333
7	1,264
8	1,264
1	1,169

As shown, the County has the most generous overall package of benefits for its HMO participants, compared to HMO plan participants at the other governmental agencies surveyed. The average for the other employers is 1,297 points.

The County is 12.9% above the average for PacifiCare, 9.0% above average for Alliant and 10.9% above average for the average of the two for medical, dental and vision benefits.

If we weight the total value based on the actual participation (that is, over half the participants are in KingCare Preferred, so we give that plan over half the weight), we find that the County's health benefits are 12.2% above the average of the other agencies.

To determine how effective the County has been in negotiating on its insured plans and how efficient the self-insured programs are, we divided the annual per employee cost of each plan by the point value we calculated, to determine a number of dollars paid per point. We found the following results for the freedom-of-choice medical plans:

Employer	Type of Plan	Dollars per Point
5	PPO	$4.64
1	PPO	4.63
King County	PPO (Deputy Sheriffs)	4.34
King County	PPO (KingCare Preferred)	4.22
1	PPO	4.21
King County	PPO (PT Transit - Preferred)	4.15
6*	PPO	4.11
3	PPO	4.03
2	PPO	4.03
2	PPO	4.01
2	PPO	3.98
5	POS	3.95
King County	PPO (PT Transit - Basic)	3.95
2	PPO	3.93
4*	POS	3.92
7*	PPO	3.92
8*	PPO	3.92

Employer	Type of Plan	Dollars per Point
4*	PPO	3.89
3	PPO (Public Safety)	3.75
King County	POS (PacifiCare Choice)	3.73
King County	POS (PT Transit)	3.56
King County	PPO (KingCare Basic)	3.45
6*	POS	3.35
2	PPO	3.28
2	PPO	3.25
2	POS	3.10
2	POS	3.09
1	High Deductible	2.52
1	PPO (Public Safety)	2.43

* Cost of vision plan is included in medical plan.

The County pays an average of $3.91 per point for its freedom-of-choice medical plans. The average for the other employers is $3.84, which means the County pays 1.8% more than average.

The County's costs for its freedom-of-choice medical plans (the PPOs and point-of-service plans) are reasonable, given their value.

If we look only at cost, without regard to plan value, we find that the County's freedom-of-choice medical plans are 12.0% more expensive than average and that KingCare Preferred is the most expensive plan at 30.0% above average.

We found the following results for the HMOs:

Employer		Dollars per Point
3		$5.40
1		4.75
King County	(PacifiCare - Deputy Sheriffs)	4.19
7*		3.92
8*		3.92
7*		3.91
8*		3.91
7*		3.84
8*		3.84
7*		3.82
8*		3.82
7*		3.79

Employer	Dollars per Point
8*	3.79
5	3.78
7*	3.73
8*	3.73
7*	3.67
8*	3.67
King County (Alliant)	3.66
6*	3.65
2	3.58
7*	3.58
8*	3.58
7*	3.57
8*	3.57
7*	3.52
8*	3.52
7*	3.50
8*	3.50
7*	3.45
8*	3.45
2	3.44
7*	3.43
8*	3.43
2	3.37
2	3.35
King County (PT Transit - Alliant)	3.26
King County (PacifiCare)	3.19
King County (PT Transit - PacifiCare)	3.16
King County (Group Health Cooperative)	2.98

* Cost of vision plan is included in medical plan.

The County pays an average of $3.41 per point for its HMOs. The average for the other employers is $4.05.

The County is doing a better than average job negotiating with its HMOs, since its cost per point is 15.8% less than for the other HMOs.

Some of the participants in our survey include the cost of their vision plan with the medical premium. When we combined the value of the medical and vision plans we found the following:

Employer	Type of Plan	Dollars per Point
1	PPO with Option 2 Vision	$4.69
1	PPO with Option 1 Vision	4.65
5	PPO	4.63
1	PPO with Option 1 Vision (Public Safety)	4.35
King County	PPO (Deputy Sheriffs) *	4.34
1	PPO with Option 2 Vision (Public Safety)	4.31
1	PPO with Option 2 Vision	4.28
King County	PPO (PT Transit - Preferred)	4.25
1	PPO with Option 1 Vision	4.23
King County	PPO KingCare Preferred	4.23
6	PPO	4.11
3	PPO	4.06
King County	PPO (PT Transit - Basic)	4.06
2	PPO (Public Safety) *	4.01
2	PPO	3.99
1	PPO with Option 2 Vision (Public Safety)	3.97
5	POS	3.95
2	PPO	3.93
1	PPO with Option 1 Vision (Public Safety)	3.92
4	POS	3.92
7	PPO	3.92
8	PPO	3.92
4	PPO	3.89
King County	POS (PT Transit)	3.80
3	PPO (Public Safety)	3.78
King County	POS (PacifiCare Choice)	3.76
King County	PPO (KingCare Basic)	3.49
6	POS	3.35
2	PPO (Public Safety)	3.27
2	PPO (Public Safety)	3.23
2	POS (FireChiefs/Firefighters) *	3.10
2	POS (Public Safety)	3.09
2	POS (Public Safety)	3.02

Employer	Type of Plan	Dollars per Point
1	High Deductible with Option 2 Vision	2.68
1	High Deductible with Option 1 Vision	2.56

* Vision coverage is not provided for this group.

The County pays an average of $3.99 per point for its combined freedom-of-choice medical plans with vision coverage. The average for the other agencies is $3.89, which means the County pays 2.6% more than average.

The County's costs for its freedom-of-choice medical plans with vision coverage are reasonable, given the value of the plans.

The following summarizes the dollar cost per point when we combine the value of the vision and HMO medical plans.

Employer		Dollars per Point
3		$5.40
1	Option 2 Vision	4.78
1	Option 1 Vision	4.77
1	Option 1 Vision (Public Safety)	4.70
1	Option 2 Vision (Public Safety)	4.66
King County	(PacifiCare-Deputy Sheriffs) *	4.19
7		3.82
8		3.82
7		3.80
8		3.80
5		3.79
7		3.74
8		3.74
7		3.72
8		3.72
7		3.69
8		3.69
King County	(Alliant)	3.66
7		3.62
8		3.62
6		3.62
2	(Public Safety)	3.61

Employer		Dollars per Point
7		3.57
8		3.57
7		3.48
8		3.48
7		3.47
8		3.47
2		3.42
7		3.42
8		3.42
7		3.40
8		3.40
7		3.38
8		3.38
King County	(PT Transit - Alliant)	3.38
2		3.35
7		3.35
8		3.35
2	(Public Safety)	3.34
7		3.33
8		3.33
King County	(PT Transit - Group Health Cooperative)	3.31
King County	(PT Transit - PacifiCare)	3.28
King County	(PacifiCare)	3.21
2	(Fire Chiefs and Fire Fighters) *	3.18
7		3.04
8		3.04
King County	(Deputy Sheriffs - Group Health Cooperative) *	2.98

* Vision coverage is not provided for this group

The County pays an average of $3.43 per point for its HMOs. The average for the other employers is $3.88.

The County is doing an above average job negotiating with its HMOs, since its cost per point is 11.6% less than for the other HMOs, when medical and vision are combined.

We used the same methodology to determine how cost effective the County has been in delivering its dental plans. We found the following results for the freedom-of-choice dental plans:

Employer	Type of Plan	Dollars per Point
3	PPO	$6.86
King County	PPO (Public Safety)	6.02
5	PPO	5.74
2	PPO	5.73
2	PPO	5.66
6	PPO	5.44
2	PPO	5.30
King County	PPO (Regular Employees)	5.22
1	PPO	5.12
1	PPO	5.11
King County	PPO (PT Transit)	5.02
4	PPO	4.67
7	PPO	3.74
8	PPO	3.74

The County pays an average of $5.42 per point for its freedom-of-choice dental plans. The average for the other plans is $5.11, which means the County pays 6.1% more than average.

The County's costs for its dental plans are reasonable, given the value of the plans.

We also compared the costs per point for the vision plan provided by the survey participants. We found the following results for the vision plans:

Employer	Dollars per Point
1	$8.52
1	7.56
3	5.45
5	4.11
2	3.82
King County	3.17
King County (PT Transit)	3.03
2	2.89

Three of the participants include the cost of their vision plan in their medical plan; we were not able to do a comparison of cost by point for these plans. The County pays an average of $3.10 per point for its vision plan. The average for the other employers is $5.24.

The County is doing a much better than average job delivering for its vision plan, since its cost per point is 40.8% less than for the other vision plans.

From 1998 to 1999, the County's actual increases in premium or budget for its freedom-of-choice plans were as follows:

KingCare Basic	14.31%
POS (PT Transit)	8.95
KingCare Basic (PT Transit)	8.54
POS	8.31
KingCare Preferred (PT Transit)	7.27
KingCare Preferred	6.75
Deputy Sheriffs	0

Giving all plans equal weight, the average increase was 7.73%. The average for the County's self-insured plans was 9.22%. Weighted by plan participation, the average increase for the self-insured plans was 6.98%.

From 1998 to 1999, the County's actual increases in HMO premiums were as follows:

PacifiCare (Deputy Sheriffs)	14.18%
Alliant (PT Transit)	9.55
PacifiCare (PT Transit)	9.10
PacifiCare	8.46
Alliant	5.65
Group Health Cooperative (Deputy Sheriffs)	0

Giving all plans equal weight, the average increase was 7.82%. Weighted by plan participation, the average increase for the HMOs was 7.11%.

The self-insured program cost increases are not disproportionate compared to the inflation in the HMO costs.

Our survey included questions regarding actuarial assumptions about inflation (known as "trend"). We found the following medical trend assumptions:

Employer	Medical Trend
4	8.8
3	8.4
King County	8
1	7
2	7

Note: The employer numbers above and below are not the same as in the rest of this section.

We found the following dental trend assumptions:

Employer	Dental Trend
1	5
2	4.8
King County	4.5
3	2.6

Only one other employer reported vision trend. The County's actuary used 5% vision trend in the most recent calculations. The other employer reported using 12.7%.

The County trend assumptions reported above were used in setting the 1999 budget. The survey asked other employers to report the assumptions used most recently. For the year 2000 budget, the County's actuary is assuming 5% trend for dental, vision and medical (excluding prescription drugs) and 15% for prescription drugs. The County's consultant is also estimating a 12% increase in HMO premiums.

The County's trend assumptions are reasonable.

The County should consider adopting a prescription drug case management program similar to one adopted by the City of Portland.

The City of Portland reports significant savings in prescription drug costs while improving the quality of care. Patients often suffer from drug therapy problems, including drug interactions, side effects and poor compliance. Most drug utilization review systems screen for these factors, but they generally are not sophisticated enough to identify many instances of inappropriate drug therapy. For example, one patient scheduled for ulcer surgery was identified as taking a medication that causes ulcers. It would be possible to run a pilot program to test the value of prescription drug case management before deciding whether to implement the program for all employees.

ACTUARIAL FEES

The County's actuarial fees are reasonable.

We evaluated the cost of actuarial consulting service to the County's self-insured benefit plans. To address these concerns, we surveyed other large governmental self-insured programs in Washington.

In 1998, the County paid William M. Mercer, Inc. $318,312.12 for consulting services. Of this, Mercer reports that $165,061.87 was for communications consulting. The other $153,250.25 breaks down as follows:

- $55,539.50 for client meetings and preparation
- $42,301.25 for vendor discussions, meetings and contract renewals
- $28,236.50 for reserves, budget and other financial experience
- $27,173.00 for project management and legal research.

The financial component is made up of $23,548.25 for actuarial analysis and $4,688.25 for other financial activities. The $23,548.25 for actuarial analysis covers all the self-insured programs -- medical, dental and vision.

Only two survey participants responded to our question regarding actuarial fees. One reported a fee of $20,000 for a medical plan. The other reported a fee of $4,500 for a medical and dental plan. One other employer reported a fee of zero, which we have disregarded for purposes of this analysis.

The larger fee equals $22.86 per employee, the smaller fee equals $4.06 per employee in the medical plan. The County's actuarial fee is $3.87 per employee in the medical plan.

Expressed as a percentage of paid claims, the respondents' fees are 0.79% and 0.09%. For the County, actuarial fees are 0.06% of paid claims.

Based on the survey results and our experience, the County's actuarial fees are reasonable.

ADMINISTRATION

This report section presents our analysis of the efficiency, effectiveness and reasonableness of the organization, rules and administrative activities of the County's self-insured employee benefits program, including an assessment of the adequacy of compliance to legal/administrative requirements. It also reports on the County's accuracy and timeliness in filing information with the State as required by self-insurance program laws.

To address these issues, we interviewed a number of people from the Benefits Office, Aetna US Healthcare, Washington Dental Service, Vision Service Plan, ProBusiness Administrative Services, William M. Mercer, Inc. and the State of Washington. Appendix II identifies the titles of the people we met with. We also reviewed a number of documents relating to the County's plans, including administration agreements, booklets and audit reports.

BENEFITS AND WELL-BEING SECTION

The Benefits and Well-Being Section of the Office of Human Resources Management (Benefits Office) has a knowledgeable and talented leadership team, which has already recognized a number of opportunities for improvement, such as training staff and documenting procedures and is also doing an excellent job in communication with employees.

Organization

Appendix III displays the current organization of the Benefits Office.

There are 21 employees in the Benefits Office. To run the Benefits Office efficiently, it is divided into teams with team leaders. The manager, the team leaders, two specialists and a temporary trainer compose the leadership team for the department.

Two members of the Benefit Services team are working on the project implementing the PeopleSoft payroll and human resource information system. This team is responsible for entering new enrollment information and changes to the data base, providing benefit information to employees and their dependents, administering the Family and Medical Leave Act, notifying the COBRA administrator of qualifying events and handling LTD, life insurance and claim problems. Until PeopleSoft is implemented, all benefit and eligibility information is loaded onto two different payroll systems: the County system and the Metro system.

The WorkLife team is responsible for in-house Employee Assistance Program (EAP) functions.

Two members of the Business Systems team are members of the leadership team. The Communications Specialist is in charge of 14 different communication mechanisms, including the continuous communication on the Intranet and daily, weekly, monthly, quarterly and annual communication. He is responsible for setting up all forms and benefit booklets on the Intranet so they can be accessed on line and downloaded onto employees' personal computers. He hopes to put this information on the Internet as soon as the modifications making the materials more user friendly have been completed; this is being done with the aid of their benefit consulting firm,

William M. Mercer, Inc. Placing this information on the Internet will allow employees and their family members to access it from home.

The duties of the financial officer for the Benefits Office include overseeing 21 vendor contracts; he reviews payments to make sure the services paid were actually rendered and takes an active role in contract renewals and bidding procedures. He prepares monthly tracking reports to monitor expenditures and reserves. He reviews the eligibility information merged from the two payroll systems for accuracy and acts as a facilitator for the three people responsible for entering eligibility into the database. Self-insured claims are paid twice weekly; he does a reasonableness check on the amount and fluctuations before payment is released. He is also in the process of reviewing and documenting procedures so that more efficient processes can be established.

The manager and her staff have developed a business plan that includes a restructuring of the department; new job descriptions and procedures to implement these are being written. This is part of a formal process improvement initiative. New hires will be selected based on their ability to fill these expanded positions.

Workflow

Workflow in the Benefits Office is logical, but not documented and sometimes implemented inconsistently. The major workflow issues of concern relate to inaccurate eligibility information in the legacy systems.

Eligibility problems have been difficult to resolve because the computers are not set up so that benefits staff can see payroll screens. This problem will be eliminated with the implementation of the PeopleSoft system, which is in progress.

The Benefits Office should prepare an administration manual.

The Benefits Office has completed flow charts describing the current processes. Improving processes should decrease the number of phone calls from employees.

At the time of the Metro/County merger, most of the staff was clerical and had not been hired to do the jobs now required. The development of the Benefits Office was impeded due to a resistance to change as well as the clerical staff not having the necessary skills. Most of the employees at the time of the merger had clerical skills, but not knowledge of benefit laws or customer service training. There is no administration manual for the Benefits Office and in the past, procedures have not been documented. The lack of written procedures, combined with the lack of skills has hindered the department by allowing inconsistent administration.

Training

In the past, training of staff in the Benefits Office was done informally. As a result, procedures are inconsistent. Lack of formal policies and procedures promotes errors and inefficiency and to combat this a training program and scripts are being developed in order to standardize procedures and answers to employees.

The County has hired a full-time trainer on a temporary basis to write formal policies and procedures and train Benefits Office personnel as to how to implement the procedures.

Customer Service

The Benefits Office currently receives between 100 to 200 telephone calls per day. Call volume increases when there are plan changes and open enrollment periods. The Benefits Office staff is not trained or skilled in answering telephone inquiries. At the present time, however, all staff members are required to spend 8 to 12 hours each week answering phone calls. The manager is preparing a feasibility study on a call center that would be shared with Safety and Claims. The purpose of the call center would be to answer questions and provide assistance to employees and managers when the self-service tools (such as the Intranet) do not meet the needs. The feasibility study includes an examination of the merits of a voice mail system that includes automated answers to frequently asked questions.

Appeals

The County should formalize its appeal procedure in writing. The County should also maintain a record of its decisions so that similar cases can be resolved in a consistent manner.

The County relies on the individual carriers and administrators to handle the initial levels of appeals. Their processes have been reviewed by the County. When all appeals with an administrator have been exhausted, the administrator refers the employee to the Benefits Office. When an initial appeal is received by the Benefits Office it is forwarded to the proper carrier or administrator for handling. The staff tries to work with both the employee and the carrier to resolve the problem. The Benefits Office does not intend to re-evaluate the adjudication process and they try to intervene only on a case with extenuating circumstances. If the person who handles claim problems cannot handle the problem it is referred to the team leader or manager. The Benefit Office works with the carriers and administrators to ensure that all decisions are fair, legal and consistent. Due to the fact that the County handles appeals concerning eligibility and appeals that have been referred by the administrators, the County should formalize its appeal procedure in writing.

Systems

While County and Metro benefits have been merged, two payroll systems still exist. Under one system, the Benefits Office is only credited with income quarterly, which causes artificial fluctuations in the claim fluctuation reserve (CFR). Another problem is a large amount of inaccurate information. With the implementation of the PeopleSoft System, the transfer of eligibility records for benefits should be much smoother and more accurate. Bad data will migrate to the new system, but once the County is on the new system, it should be easier to identify and correct data problems with incorrect information.

Employee Communications

The goal of the Benefits Office is to educate employees so they make good benefits decisions; in keeping with this goal, there are at least 5 opportunities each month to meet with the employees at orientation meetings. Over 90% of the new employees attend these meetings, which means new employees are being well educated as to benefits.

The County has done an excellent job of using its Intranet to communicate employee benefit information. The County should continue to expand this application by making more information available on the Internet and by allowing forms to be completed on line.

One study calculated a savings of over $5 for every employee who uses the Internet to submit open enrollment elections.

Reserves and Financial Analysis

The Benefits Office should institute financial controls and monitor the accuracy of data received from other departments.

Incurred-but-not-reported (IBNR) reserves are adjusted twice each year based on information from the actuary. The actuary uses monthly lag report and claim information in her determination.

The financial officer for the Benefits Office monitors the self-insured plan CFR reserves. The CFR is the cash balance in the Benefits Office account, adjusted for accruals, including the IBNR. According to his calculations the CFR had fallen to about $260,000 by the end of March. The actuary questioned this result because claims were not unexpectedly high. Further research showed that the benefit budget had not been fully credited with income. Once the cumulative effects of this error had been corrected, the CFR at the end of April was almost $1.9 million. Another reason for the large change between the end of March and the end of April is the fact that one computer system only credits the Benefit Office with its funds quarterly.

Staffing

The County should study the activities being performed in the Benefits Office to determine if there are any that can be discontinued and if there is adequate staff to perform the necessary activities.

A thorough review of the staffing levels in the Benefits Office was beyond the scope of this study. However, based on our experience, it is our perception that the Benefits Office is not adequately staffed to perform all the functions that are currently being done or need to be done.

Performance Measures

Mercer should be more assertive in monitoring the performance standards in order to be sure the administrators are serving the County properly.

The County has negotiated performance standards with its medical, dental and COBRA administrators. The County maintains information on the standards, but relies on its consultant, William M. Mercer, Inc. to monitor adherence to the standards. Monitoring consists primarily of obtaining reports from each administrator. When we visited Mercer on May 13, 1999, Mercer still had not obtained all the 1998 reports.

The medical and COBRA administration contracts should be updated.

As noted, in the sections on medical and COBRA administration, the contracts are not up to date regarding performance standards. The contracts should accurately reflect the understandings between the parties.

The department has developed the following performance measures for its own customer service:

- Response time of less than 20 seconds to answer the telephone
- Less than 5% of calls abandoned before answer (abandonment rate).

These standards were developed based on the performance of the best 25% of call centers, as measured by the International Quality and Productivity Center. The department has consistently exceeded these standards, as shown below:

Year	# of Calls	Average Calls/Day	Response Time (In Seconds)	Abandonment Rate
1997	41,333	165	12	3%
1998	38,532	155	13	3%
1999*	15,183	149	16	4%

* 1999 data is from January through May.

The declining number of calls per day indicates that the County's other communication efforts, such as new employee orientations and the Intranet, are succeeding.

Other measures not related to telephone service are also being developed, such as customer satisfaction, cost and staffing measures.

External Audits

The County should conduct regular audits of its third party administrators.

It has been two years since the County has audited any of its third party administrators. Given the large dollar volume the medical plan administrator is processing for the County, the County should conduct annual audits. The County should conduct audits of the dental plan administrator at least every two years and audits of the prescription drug, vision and COBRA administrators at least every three years.

The County should conduct competitive bidding for the claim audits.

The County has used its benefit consultant, Mercer, to conduct audits in the past, but Mercer only conducts audits on behalf of the County when requested to do so. This function could be performed by Mercer or another firm.

Strengths

The Benefits Office has a knowledgeable and talented leadership team, which has already recognized a number of opportunities for improvement, including:

- The need to reorganize the department
- The need for a call center
- The need for additional financial analysis
- The need for an administration manual
- The need for a training program
- The need for job descriptions.

The Benefits Office is already doing an excellent job in a number of areas, including:

- Extensive new employee benefit orientations
- Excellent communications, particularly on the Intranet
- Excellent customer service.

THIRD PARTY ADMINISTRATORS

We reviewed the efficiency, effectiveness and reasonableness of the organization, rules and administrative activities of the self-insured employee benefits program. As part of this review we visited the offices of the medical plan administrator (Aetna), the dental plan administrator (WDS), the vision plan administrator (VSP) and the COBRA administrator (ProBusiness).

As a part of our review of the administrative practices and procedures of each administrator, we were looking for:

- Logical organizational structure
- Adequate staffing levels
- Logical workflow
- Appropriate management of any backlogs
- State-of-the-art computer systems
- Good customer service procedures and systems
- Documented appeal procedures
- Appropriate internal quality review procedures
- Adherence to contractual obligations

- Appropriate deposits and funding procedures
- Knowledgeable management
- Experienced and well trained staff.

The following sections note deviations from these expectations, as well as any other pertinent findings and recommendations.

Medical Plan Administration

Aetna US Healthcare (formerly known as Ethix) administers the County's self-insured medical plan, which has two options: Basic and Preferred. The plans are identical in terms of covered expenses, exclusions and networks, but the deductibles and coinsurance amounts are different.

Workflow

Aetna US Healthcare (AUSHC) reports that the average processing time is 11 days. The goal of this Aetna unit is to process 85% of the claims within 14 calendar days.

AUSHC should intentionally overstaff in advance of the system conversion to allow for system training and to maintain service levels.

All claims are still being processed on an old system; they have not set a date for the conversion of County claims to the AUSHC platform.

Turnaround Time Management

Aetna should take steps to assure timeliness before it fails to meet its standards, not afterwards.

A weekly report is prepared showing the number of claims processed and the processing time. If the report shows that processing has fallen below 80% in 14 days the manager and supervisor meet to discuss why. They then take steps to reduce the backlog, which include overtime, borrowing of processors from another unit or management paying claims. At the time of our visit there were 4,000 County claims on the system and about 300 waiting to be registered. The number of claims on the system was up due to the conversions taking place as clients are moved from the old computer system to the AUSHC system.

The current procedure calls for them to take corrective steps after a problem has developed; AUSHC should act sooner to prevent problems by requesting overtime or reallocating staff.

Performance Standards

The guarantees AUSHC has made to the County include:

- Processing 85% or 90% of the claims not requiring investigation within 14 days
- Achieving financial accuracy of 98.5%

- Answering all telephone calls within 45 seconds.

The contract should be updated to reflect both the new name for AUSHC and the correct performance standards.

The contract between the County and Ethix indicates that the timeliness standard is 90%. Both AUSHC and the County are under the impression that it was changed to 85%.

External Audits

The County's employee benefit consultant, William M. Mercer, Inc. conducted audits of Ethix in 1996 and 1997. The 1996 audit found that Ethix was below standard in a number of categories (as measured by the Ethix internal standards and the performance standards above), which prompted the follow-up audit in 1997. The 1997 audit showed significant improvement, but Mercer still concluded Ethix was below standard in a number of categories.

The State of Washington Office of Risk Management recommends audits every three years.

Given the large dollar volume AUSHC is processing for the County, the County should conduct annual audits.

There are no legal requirements to conduct audits, but the County would not turn in excess of $20 million over to a County employee without checking up on it; the County should not treat AUSHC any differently.

Express Scripts manages the prescription drug benefits as a subcontractor to AUSHC. The County has not audited Express Scripts.

Audits of the prescription drug program should be conducted at least every three years, possibly more frequently, depending on the findings in the initial audit.

Dental Plan Administration

Washington Dental Service (WDS) administers the County's self-insured dental plan.

Systems

It would be wise for WDS to overstaff during the conversion process to prevent adding to the backlog.

WDS is currently using the Claims Management System but is going through a conversion to a new computer system that provides real-time processing. The new system will ultimately allow the providers to do data entry of claims in their offices. It is designed to reduce manual intervention and people. Several members of the claims area have been actively involved in the testing of this new system.

Overpayments

The contract obligates WDS to notify the County of all overpayments in excess of $500. WDS is not meeting this obligation.

WDS should establish a procedure to comply with the overpayment reporting requirement.

This is not a significant problem, but it is a contractual obligation that has not been met. WDS does have a procedure in place to recover overpayments and credit the County.

External Audits

The County's employee benefit consultant, Foster Higgins (since acquired by William M. Mercer, Inc.) conducted an audit of WDS in 1996. The audit found that claim processing accuracy was below standard, as measured against the performance standards in the contract between WDS and the County.

The State of Washington Office of Risk Management recommends audits every three years, which means another audit is due.

Given the dollar volume WDS processes for the County, the County should conduct audits at least every two years.

In 1995 WDS was audited by the Office of the Insurance Commissioner. Only six errors were found in the 250 claims audited. Based on this audit, they received 10 instructions for changes and 10 recommendations. Most of the instructions had to do with advertising and other issues not pertinent to the County, meaning that the commissioner's auditors generally did not find problems that would affect the County. One recommendation was that management review complaints. Another was that some messages on the explanations of benefits forms sent to employees be clarified. We were informed that all of the instructions and recommendations were implemented.

Vision Plan Administration

Vision Service Plan (VSP) administers the County's self-insured vision plan.

External Audit

The County's employee benefit consultant, William M. Mercer, Inc. conducted an audit of VSP in 1997 and concluded that VSP was providing service that was slightly below standard, as measured by VSP's internal standards, primarily because the plan was not being administered in accordance with some provisions. VSP was processing claims consistent with its standard provisions, not with the provisions of the County booklet. Mercer followed up with VSP and the County. The issue of the County's non-standard benefit provisions was brought to the Joint Labor Management Insurance Committee, which decided to retain the non-standard provisions and instruct VSP to change its practices prospectively.

The County should conduct another audit of VSP, no later than next year, which will be three years since the last audit. The County should audit VSP at least every three years,

which is consistent with the recommendation of the State of Washington Office of Risk Management.

COBRA Administration

ProBusiness Administrative Services (formerly known as Benesphere) is the County's administrator of the group health continuation coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as COBRA). ProBusiness also sends certificates required by the Health Insurance Portability and Accountability Act (HIPAA) to all COBRA continuees at the time of termination of COBRA. ProBusiness also collects retiree medical premiums for the County. ProBusiness is also the County's administrator for its flexible spending accounts (FSAs); however, review of that aspect of administration was outside the scope of this study.

Workflow

The County notifies ProBusiness of qualifying events as defined by COBRA. The County provides this information on paper, whereas most ProBusiness clients provide it electronically.

The County should explore the feasibility of providing qualifying event information to ProBusiness electronically, as soon as the conversion to PeopleSoft is complete.

Sending information electronically will be faster and more accurate.

COBRA includes deadlines for sending certain notices. ProBusiness obtains a certificate of mailing with each notice sent at the time of a qualifying event. The certificate does not require anyone to sign for receipt, but ProBusiness is notified if the letter cannot be delivered. If that occurs, ProBusiness calls the County in an attempt to obtain an accurate address.

Organization and Staffing

ProBusiness is in the midst of a significant reorganization. In the past, ProBusiness has had separate COBRA and FSA departments. ProBusiness is in the process of creating a single Customer Service unit that will answer calls on both COBRA and FSAs, as well as the enrollment function. Creation of the call center was behind schedule; when Benesphere submitted its proposal to the County, it said the call center would be in place by June 1998. ProBusiness has just moved to new quarters in late May and the change in organization came at the time of the move (our site visit took place shortly before the move.) If a Customer Service representative (CSR) cannot answer a question, it will be referred to the client services manager for the County. If he cannot answer the question it will go to the COBRA manager and from there to the Chief Operating Officer (COO).

Systems

ProBusiness is in the process of converting from the COBRAEAS software package to the Travis software package. The County's transition to Travis has not yet been scheduled because the direct debit program (whereby COBRA premiums are taken from checking accounts) needs to be re-written for the Travis software. Additionally, the date of birth is a required field in the Travis software and ProBusiness does not have dates of birth for all County COBRA continuees because

the forms the County uses to notify ProBusiness of qualifying events do not include the date of birth.

The County should begin providing the date of birth for each COBRA continuee to ProBusiness as soon as possible, because this field is required by the new system.

ProBusiness should ensure that it has adequate staff to allow a smooth transition to the Travis Software.

The present system is inflexible regarding the content of letters. We found many of the letters to be confusing. The new system will allow customized letters for each client.

ProBusiness should revise its letters for clarity and that the County review and approve all new standard letters.

Performance Standards

The contract between the County and Benesphere that we obtained from the County does not include any performance standards; however, both ProBusiness and the County are under the impression that such standards exist. Contracts should accurately reflect the understanding between the parties. Therefore,

The contract should be updated to reflect both the new name for ProBusiness and the performance standards.

External Audits

The County has not audited ProBusiness.

Given the large number of changes at ProBusiness -- reorganization, move, system -- the County should conduct an audit in the near future and at least every three years in order to assure that ProBusiness is meeting legal requirements and thereby protecting the County from lawsuits.

LEGAL REQUIREMENTS

We reviewed the adequacy of compliance to any legal/administrative requirements. To do so, we reviewed numerous documents and met with County staff and State regulators.

Federal

Numerous Federal requirements apply to the County's plan design and administration, including the requirements of:

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- The Family and Medical Leave Act of 1993 (FMLA)
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)
- The Mental Health Parity Act of 1996 (MHPA)
- The Women's Health Act of 1998 (WHA).

Additionally, there are pertinent provisions of the Internal Revenue Code, such as the requirement to impute income to employees who cover domestic partners unless the partner qualifies as a dependent.

The County is meeting all applicable Federal legal requirements regarding plan design and most federal notice and administrative requirements.

The County's plan design meets all applicable Federal requirements. The County needs to modify its booklets to include recent changes in the law regarding notice requirements. The County's benefit consultant has drafted a new booklet for the self-insured medical plan. We wrote to the Benefits Office with our comments on the draft and with comments on other communication materials and contracts. Our letters are included as Appendix IV.

The Omnibus Budget Reconciliation Act of 1993 requires employers to have written procedures for handling Qualified Medical Child Support Orders. The County appears to be handling orders properly, but does not have a written procedure. The Benefits Office is beginning to document its procedures; this procedure should be given higher priority because it is legally required.

There are two gray areas related to COBRA administration. The first is whether an Employee Assistance Program (EAP) is a group health plan for COBRA purposes. The County has chosen not to offer EAP coverage to COBRA continuees, which is a common choice by employers.

The second gray area is whether each qualified beneficiary should be offered independent elections for medical, dental and vision coverage. Part-time transit workers are offered independent elections for COBRA because active employees are. Other employees are only offered a choice between a package of medical, dental and vision coverage or medical only.

Earlier this year, the Internal Revenue Service issued final regulations under COBRA. Technically, these regulations do not apply to the County, but the IRS is interpreting statutory language that is parallel to the language in the Public Health Service Act (PHSA), which does apply to the County. The Department of Health and Human Services is responsible for enforcing the PHSA, but has not issued any guidance. Therefore, the IRS regulations are all that exists regarding this statutory language. It would be appropriate to rely on the IRS regulations. Unfortunately, they are not as clear on this point as we would like.

The regulations require that each qualified beneficiary be allowed to make an independent election for each plan. For example, if an employer has three separate plans for medical, dental and vision, then each qualified beneficiary could choose whether to take each plan separately, rather than the package approach used by the County for most employees.

The preamble to the regulations says they give employers "broad discretion to determine the number of group health plans that they maintain." However, the preamble goes on to state that the status of plans as separate or part of a single plan is determined by reference to the

instruments governing those arrangements. If it is not clear whether the plans are separate, then all plans are deemed to constitute a single plan.

The primary instruments governing the County's self-insured plans are the booklets given to employees and the contracts with the administrators. Each of these documents is separate, which could be the basis for an argument that each plan is separate. On the other hand, communication materials given to new employees and at open enrollment are combined, which could be the basis of an argument that the plans should be treated as a single plan. In order to comply with the letter of the law,

The County should either create a single plan document governing all three plans or offer separate COBRA elections for each plan.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) includes group health plan continuation requirements that are very similar to COBRA. These requirements apply to any County employee who enters active service in the military. USERRA differs from COBRA with regard to certain rules on premiums and termination of coverage. ProBusiness is not familiar with USERRA.

Since there may be times when COBRA needs to be coordinated with USERRA, ProBusiness should become familiar with the requirements of USERRA.

State

Under Washington State law, public employers must receive approval from the Office of Risk Management to self-insure employee benefit plans. Public employers are also required to submit periodic reports and are subject to monitoring by the State.

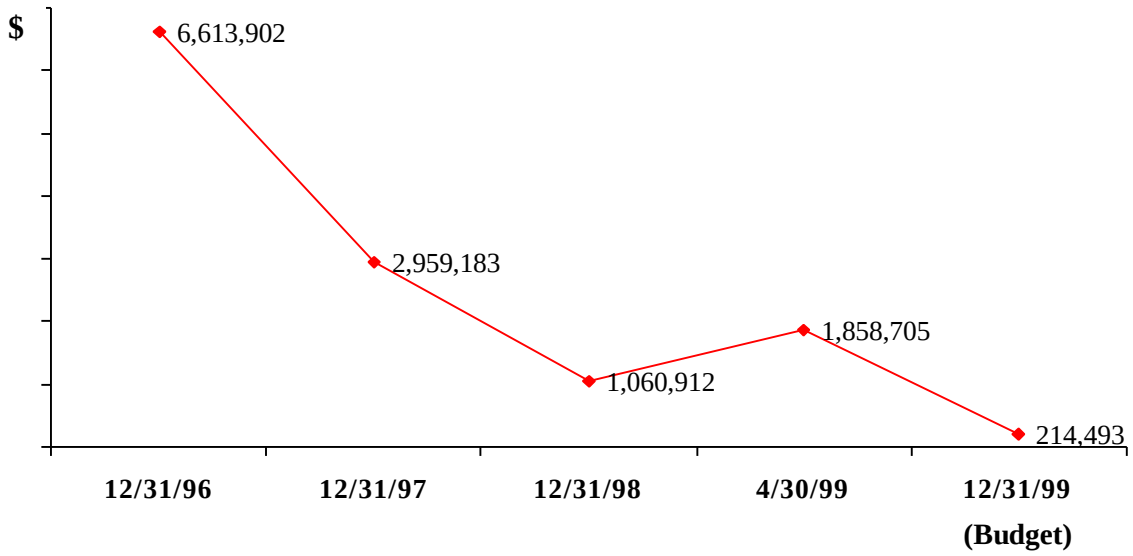
At this time, the County does not have a fully funded IBNR; otherwise the County is in compliance with all applicable State laws.

However, the State's Health and Welfare Advisory Board is considering adding a requirement that claim fluctuation reserves be funded, which may require the County to fund a claim fluctuation reserve of about $6.4 million.

When the County first requested approval to maintain a health and welfare self-insurance program, it submitted a budget calling for a claim fluctuation reserve (CFR) of $5.2 million, which was approximately 15% of annual expenditures at that time (including administration and HMO premiums). No explicit commitment to maintain this level of funding was made. As of the end of June 1999, the CFR had been exhausted.

The amount of this reserve fluctuates inversely with claim fluctuations. The County calculates its CFR as the cumulative excess of the budget over claims and other expenses. The reserve has now been depleted by claim fluctuations and the County is in violation of the State's requirements that the IBNR be fully funded. The Office of Risk Management is aware that the County's reserves are low and is monitoring the level monthly.

The following graph shows the general decline in the County's CFR:



The County may need to increase the CFR to comply with a pending change in State rules.

A Health and Welfare Advisory Board advises the State regarding self-insured health and welfare plans. The Board is considering adding a requirement that CFRs be funded. The most likely requirement is 14% of expected paid claims and expenses. If the Board recommends such a requirement and if the State adopts it, the County would need to fund a CFR of approximately $6.4 million. The Board may allow larger agencies, such as the County to have a smaller percentage. The Board may also allow a transition period, rather than requiring that the full amount be funded immediately.

If the State adopts a 14% CFR requirement, the County should re-examine whether self insurance is still advantageous, compared to insuring the benefits.

In order to be considered a CFR by the State, funds must be dedicated to employee benefits and not allocated to any other purpose. This means that designating other funds as available for benefits in an emergency will not satisfy any requirements the State may develop.

County Ordinance

The County's insurance carriers and HMOs refuse to comply with the terms of a County ordinance related to benefits for employees (and their dependents) who are on military leave.

The federal Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), requires offering health plan continuation for 18 months. Prior to the enactment of USERRA the County enacted an ordinance continuing all employee benefits for employees on a military duty leave without a time limit. The Benefits Office can comply with the ordinance under its self-insured programs, but the HMOs and life and disability insurers refuse to assume any more risk than required by USERRA.

The Benefits Office could transfer people in HMOs to the self-insured plan in order to comply with the ordinance. The County could self-insure the life and disability benefits for employees on military duty leave. The proceeds would be taxable. The major drawback to this approach is the cost of providing death and disability benefits to people in combat, which is why the insurers refuse to offer these benefits.

The County has two options: self-insure the benefits, which could be expensive, or the Council could repeal the ordinance.

Appendices I through V are available by contacting King County Auditor's Office:

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